

Health & Welfare Plan Reporting and Disclosure Checklist		Responsible Party	Compliance check Indicate results below <i>Illustrative audit results provided; tailor to your own situation.</i>
Note: This material is for the sole purpose of providing general information and does not under any circumstances constitute legal advice. You should seek the advice of counsel when applying the requirements to your plans.			
What	When		
Summary Plan Description (SPD)	<ul style="list-style-type: none"> ▪ Within 120 days of plan becoming subject to ERISA ▪ Within 90 days of becoming a participant or beneficiary ▪ Updated SPDs must be distributed every five years if changed or every 10 years if no changes 		<i>Latest SPD updated to plan changes mm/yy SPD distributed by (indicate who distributed and when)</i>
Summary of Material Modifications (SMM)	No later than 210 days after the end of the Plan year in which the change is adopted		<i>Distributed as part of open enrollment material</i>
Summary Annual Report (SAR)	Within 9 months after the end of the Plan year or 2 months after filing the Form 5500.		
Plan Documents under which the plan is operated	<ul style="list-style-type: none"> ▪ Copies must be furnished no later than 30 days following written request ▪ Made available at principal office and certain other locations. 		<i>Plan documents maintained by (indicate whom) Plan documents last updated (indicate date)</i>
Summary of material reduction in covered services or benefits	Generally within 60 days of adoption of material reduction in group health plan services or benefits.		
Notices			
CHIPRA	This notice must be provided by the later of (1) the first day of the first plan year after February 4, 2010; or (2) May 1, 2010, i.e., January 1, 2011 for calendar-year plans. The Notice is required to be provided on an annual basis. The Model CHIP Notice can be found at the DOL website.		
Initial COBRA notice	Within 90 days of the later of the date plan coverage begins or the first date the plan becomes subject to COBRA		

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COBRA election notice	<ul style="list-style-type: none"> ▪ Employer must notify plan administrator within 30 days of employee's death, retirement, termination, reduction in hours or date of loss of coverage ▪ Plan administrator must notify employee within 14 days after being notified of the qualifying event Note: if employer and plan administrator are the same, the notice requirement is 44 days.		
COBRA premium insufficiency	Upon insufficient premium.		
Notice of Unavailability of COBRA	If applicable, within 14 days after the plan administrator receives a notice of a qualifying event.		
COBRA early termination	Upon any termination of COBRA coverage that will occur before the maximum period of COBRA coverage.		
HIPAA Privacy Notice	<ul style="list-style-type: none"> ▪ at the time of enrollment for new enrollees ▪ upon request ▪ within 60 days of a material change to the Notice ▪ no less frequently than once every 3 years. 		
HIPAA certificate of creditable coverage	<ul style="list-style-type: none"> ▪ Upon losing group health coverage ▪ Upon becoming eligible for COBRA ▪ When COBRA coverage ceases ▪ Upon request anytime before losing coverage and within 24 months of losing coverage 		
HIPAA notice of pre-existing	<ul style="list-style-type: none"> ▪ Before any preexisting condition may be applied to any individual. 		

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condition exclusion	<ul style="list-style-type: none"> ▪ Notice may be included in a group health plan's enrollment material 		
HIPAA individualized notice of pre-existing condition exclusion	Within a reasonable time after participant or covered dependent provides evidence of prior creditable coverage.		
HIPAA notice of special enrollment rights	On or before the time an employee is offered an opportunity to enroll in the group health plan. Effective 4/1/2009, CHIPRA added an additional special enrollment opportunity.		
NHMPA (newborn)	<ul style="list-style-type: none"> ▪ Include in SPD/SMM; SPD/SMM timeframes applicable. 		<i>Included in SPD</i>
Women's Health and Cancer Rights Act notices (WHCRA)	<ul style="list-style-type: none"> ▪ Upon enrollment ▪ Annually 		<i>Included in new employee orientation kit and annual open enrollment and in SPD</i>
Medical Child Support Order (MCSO)	<ul style="list-style-type: none"> ▪ Upon receipt of MCSO, administrator must issue notice including procedures for determining qualified status. ▪ Notice regarding qualified status 		
National Medical Support Notice (NMS)	<ul style="list-style-type: none"> ▪ Employer must send Part A to the State agency or Part B to the plan administrator within 20 days after the date of the notice or sooner if reasonable. ▪ Administrator must notify affected persons of receipt of the notice and procedures for determining qualified status. ▪ Within 40 business days after its date or sooner, administrator must return Part B to the state agency and provide information 		

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	to affected persons.		
Medicare Part D Creditable Coverage Notice	<ul style="list-style-type: none"> ▪ Before the beginning of Medicare Part D annual enrollment period ▪ Before an individual is first eligible for Medicare Part D ▪ Before the effective date of coverage for any Medicare eligible individual that joins the plan ▪ Whenever prescription drug coverage ends or changes so that it is no longer creditable or becomes creditable ▪ Upon request 		
Health Care Reform Notices			
Grandfather Notice	To maintain status as a grandfathered health plan, a plan or health insurance coverage must include a statement, in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan or health insurance coverage, that the plan or coverage believes it is a grandfathered health plan. A model notice can be found at the DOL's website.		<i>Indicate whether recent plan changes resulted in loss of grandfather status</i>
Young adult to age 26 enrollment Notice	If coverage of a dependent child ended before age 26, either the plan or the issuer must provide written notice giving the dependent the opportunity to enroll. A dependents model notice can be found at the DOL's website.		
Patient Protection Notice	Individuals enrolled in a plan or health insurance coverage know of their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization. A patient protection model notice can be found at the DOL's website.		

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Lifetime Limit Notice	Individuals who reached a lifetime limit under a plan or health insurance coverage prior to the applicability date of these interim final regulations and are otherwise still eligible under the plan or health insurance coverage must be provided with a notice that the lifetime limit no longer applies. The lifetime limit model notice can be found at the DOL's website.		
Claims and Appeals Model Notices	PPACA requires both an internal and external review process; these rules are applicable for non-grandfathered plans. Model notices can be found at the DOL's website as follows: Revised Model Notice of Adverse Benefit Determination , Model Notice of Final Internal Adverse Benefit Determination , Model Notice of External Review Decision		
Early Retiree Reinsurance Program (ERRP)	Sponsors participating in ERRP must provide a form notice to plan participants notifying them that, because the sponsor is participating in the ERRP with respect to the plan, the sponsor may use the reimbursements to reduce plan participants' premium contributions, copayments, deductibles, co-insurance, or other out-of-pocket costs, and therefore plan participants may experience such changes in the terms and conditions of their plan participation. An ERRP Model Notice may be found on the ERRP webpage.		
Annual Limit waiver	As a condition of receiving a waiver from the annual limit requirements under Health Care Reform, a group health plan must provide a notice to eligible participants. OCIO guidance 2010-1B issued December 2010 provides a sample notice		
Summary of Benefits and Coverages (SBC)	An SBC must be provided to health plan participants and beneficiaries. The SBC is a standalone document in addition to the summary plan description. Refer to ErisaALERT 2011-11 and		

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	ErisaALERT 2011-12 for more details regarding SBC content requirements. The original effective date of March 23, 2012 has been postponed pending issuance of final regulations.		
W-2 Reporting of aggregate cost of employer sponsored group health plan coverage	The Affordable Care Act required informational reporting of the aggregate cost of employer sponsored group health plan coverage beginning with 2012 W-2s issued in January 2013. The IRS provides new guidance in Notice 2012-9 which restates and supersedes previous guidance. See ErisaALERT 2012-01 for more information.		
Reporting			
Form 5500	Required for plans with 100 participants at the beginning of the plan year. The plan year is defined in the plan document and should not be confused with the policy year. The Form 5500 is due 7 months after the end of the plan year. An extension can be obtained by filing Form 5558.		
Form 8928	<p>Form 8928 must be filed by group health plans, plan sponsors or plan administrators who:</p> <ul style="list-style-type: none"> • fail to provide the required level of pediatric vaccine • fail to comply with certain HIPAA requirements • fail to make comparable Archer medical savings account contributions • fail to make comparable HSA contributions <p>Form 7004 must be filed to obtain the extension. This reporting requirement was effective January 1, 2010. More information regarding Form 8928 can be found at the IRS website.</p>		

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Comparative Research fee Note: no guidance as of the date of the chart	The Affordable Care Act established the Patient-Centered Outcomes Research Institute and provided that the institute be funded by the Patient-Centered Outcomes Research Trust Fund. The Trust Fund is to be funded in part by fees to be paid by issuers of health insurance policies and sponsors of self-insured health plans. IRS Notice 2011-35 requests comments regarding how the fees to fund the institute should be calculated and paid, including several possible rules and safe harbors.	Insurer in the case of insured plans Employer in the case of self-insured plans.	